Application For Crime Victim Compensation

Arkansas Crime Victims Reparations Board

323 Center Street, Suite 200
Little Rock, Arkansas 72201
(501) 682-1020 or 1-800-448-3014

Claim No.

Office of the
Arkansas Attorney General
Mike Beebe

This application distributed by:

(Application revised February, 2004)

This application to the Crime Victims Reparations Board must be completed in its entirety. Incomplete applications may be returned without being processed. If you need assistance completing the application, please call the Attorney General's Office at 1-800-448-3014 or (501) 682-1020. You *do not* need to be represented by an attorney to apply for or receive benefits from the Crime Victims Reparations Board. All correspondence will be sent to the below-listed address unless you specify that an alternate address and phone number should be used. Please notify our office if your address or phone number is changed.

☞ Section A – Victim/Applicant Information **(A separate application must be completed for each victim.)**

Victim's Name		Sex M / F	Date of Birth (M/D/Y)
Mailing Address		City/State/ZIP	Age at Time of Incident
Home Telephone Number ( )	Work Telephone ( )	Marital Status	Social Security

Has the Victim ever been convicted of a felony? If yes, in what state and county? Briefly explain conviction (month/year/offense)
No Yes State County

The above person is listed as Victim because:

They suffered a personal injury or death as the result of a violent crime. __Yes __No

They are the dependent or child (including by adoption) of a victim. __Yes __No

They are the spouse, parent, child, sibling, or grandparent of a deceased victim, child victim, or victim of sexual assault. __Yes __No

They resided—at the time of the crime—in the same permanent household as a deceased victim. __Yes __No

They discovered the body of a homicide victim. __Yes __No

**This information about the Victim will be used for statistical purposes only and is needed to comply with federal regulations.

Race: __White __African American __Hispanic or Latino __American Indian/Alaska Native __Asian __Pacific Islander

Referred to Reparations Board by: __Victim-Assistance Worker __Prosecutor __Hospital __Funeral Home __Law-Enforcement Agency __Poster/Brochure __Media __Other________________

Complete this section only if you are submitting this application but are different than the person listed above.

Applicant's Name	Sex M / F	Date of Birth (M/D/Y)	Relationship to Victim
Mailing Address		City/State/ZIP	Age at Time of Incident
Home Telephone Number	Work Telephone	Marital Status	Social Security

(   )   (   )

Has the Applicant ever been convicted of a felony? If yes, in what state and county? Briefly explain conviction (month/year/offense)
No   Yes   State   County

Contact person other than Victim or Applicant: Telephone
Name   Address   (   )

☞ Section B – Crime Information

NOTE: You must attach a copy of the law-enforcement agency's incident report to this application.

Type of crime:

______ Domestic Abuse (Spouse)   ______ Assault (Non-Family)   ______ Adult Sexual Assault

______ Child Sex Abuse by Family Member   ______ Child Sex Abuse by Non-Family Member   ______ Child Physical Abuse

______ Homicide   ______ DWI / Hit and Run   ______ Other ____________

Did the victim submit to a sexual assault examination? ______ Yes ______ No

Name and address of hospital: ____

Date crime occurred ________________ Date crime reported ________________ Time crime reported _________________

Address where crime occurred: ______________________________________ County: _________________________

Brief description of crime: ____

____

Was the crime reported to the proper authorities within 72 hours? ______ Yes ______ No

If no, explain why ____

Agency to which reported: ____

Address: ____ Telephone: (________) ______________

Name of agency representative, caseworker, or person handling case: ____

Who reported the incident to the proper authorities? ____

Name of assailant or perpetrator and accomplices (if known). ____

Did the victim know offender? ______ Yes ______ No If yes, in what way? ________________________________

Was the victim living with the offender at the time of the incident? ______ Yes ______ No

Has the offender been charged in court? ______ Yes ______ No

If yes, court case #: ____ Which court? ____________________________________

Have you filed, or do you intend to file, a civil law suit? ______ Yes ______ No

If yes, attorney's name/address: ____

☞ Section C – Request for Medical Treatment/ Mental-Health Counseling

☞ Check here if this section does not apply to this Victim/Applicant at this time.

NOTE: In addition to completing this section, you must attach copies of all itemized medical bills, mental-health counseling bills, or other statements verifying expenses.

I am seeking compensation for:

__ Medical Care __ Dental Care __Mental-Health Counseling __ Replacement Service Loss (child care, convalescent care, etc.)

__ Eyeglasses, hearing aids, or other medically necessary devices for the health of the victim

List any physical disabilities the victim had before the victimization: ____

Briefly describe injuries that resulted from the victimization: ____

____

List all medical expenses incurred as a result of crime related injuries, including hospital and doctor charges, counseling expenses, ambulance fees, and prescription medication costs. Attach itemized statements or bills that you have received to date.

NOTE: Statements or bills must be attached in order for claim to be processed.

Provider's Name	*Street Address*	*City/State/ZIP*	*Phone #*	*Amount of Bill*

Attach additional sheets if necessary. Will there be additional medical bills? ______ Yes ______ No ______ Unknown

Were any of the bills paid or will they be paid by any of the following sources?

Source	*Yes*	*No*	*Amount Paid*	*Identification Number*
Yourself	___	___	$ ________________	________________
Private Health Insurance	___	___	$ ________________	________________
Medicare/Medicaid	___	___	$ ________________	________________
Workers Compensation	___	___	$ ________________	________________
Veterans Administration	___	___	$ ________________	________________
Auto Insurance	___	___	$ ________________	________________
Restitution/Civil Recovery	___	___	$ ________________	________________

Name of Health Insurer: ____________________________________ Policy Number ____________________

Address: ____ Telephone: (______) ________________

Name of Auto Insurer: _____________________________________ Policy Number ____________________

Address: ____ Telephone: (______) __________________

☞ Section D—Request for Lost Wages

☞ Check here if this section does not apply to this Victim/Applicant at this time.

NOTE: To be eligible for work loss, the victim must have been employed at the time of the incident. Attach a copy of your most recent pay stub from your employer. If you are self-employed, you must furnish copies of your tax returns from the last three (3) years so lost wages can be most accurately determined. You must also provide the complete name and address of the physician who can verify your disability period, or you may attach a copy of a recent disability statement.

Do you wish to file for work loss? ______ Yes ______ No

Employer's Business Name ________________________________ Contact Person/Phone No. ____________________________

Mailing Address ______________________________________ City/State/ZIP ______________________________________

Dates absent from work due to crime related injuries: From: ___________________________ To: _________________________

How many total days were missed: _____________ How many total hours were missed? __________ Hourly wage? ____________

Do/did you receive compensation while off work? ______ Yes ______ No If Yes, complete the following:

	Amount per week	*From (date)*	*To (date)*
Workers Compensation	$ __________________	________________________	________________________
Unemployment Compensation	$ __________________	________________________	________________________
Work Loss Insurance	$ __________________	________________________	________________________
Vacation	$ __________________	________________________	________________________
Sick Leave	$ __________________	________________________	________________________
Union/Fraternal Insurance	$ __________________	________________________	________________________
Other	$ __________________	________________________	________________________

☞ Section E—Request for Funeral/Burial Expenses

☞ Check here if this section does not apply to this Victim/Applicant at this time.

NOTE: You must submit a copy of the funeral bill and the death certificate with this application.

Are you seeking funeral benefits for a deceased victim? ______ Yes ______ No

Name of funeral home ____ Telephone (______) _________________________

Mailing Address _______________________________________ City/State/ZIP _______________________________________

Total amount of funeral bill $______________________________ Have the funeral expenses been paid? ______ Yes ______ No

Were funeral expenses paid by any of the following? If yes, please list the amounts paid from each of the following sources:

Social Security	Burial Insurance	Life Insurance	Veterans Insurance	Other ________________
$ ______________	$ ______________	$ ______________	$ ______________	$ ______________

Donations	Family Members/Individuals	Name/Relationship/Mailing Address of Family Member or Individual
$ ______________	$ ______________	____
		____
		____

Burial/Life Insurance Company ____ Policy # ___________________

Mailing Address ____ Telephone: (______) __________________________

Who received the benefits? ____ Relationship to victim: _______________________

☞ Section F—Request for Loss of Support

☞ Check here if this section does not apply to this Victim/Applicant at this time.

NOTE: You must attach copies of the deceased victim's last three (3) years' tax returns. You must also provide verification regarding the denial or receipt of any benefits from the Social Security Administration. You must be the legal guardian of a minor dependent to request loss of support on their behalf and must provide verification of guardianship.

Are you requesting loss of support that resulted from the death of the Victim? ______Yes ______No

The Reparations Board may provide "loss of support" to dependents of deceased victims who were employed at the time of the incident. The person seeking this loss of support must be the guardian of any dependents for which you are requesting benefits. Complete the following in order to be considered for loss of support.

Dependent's Name	Date of Birth	Social Security Number	Relationship to Victim

Do/did you receive income from any of the sources listed below? ______ Yes ______ No

	Amount per month
Social Security	$ ____________________
Welfare	$ ____________________
Aid to Dependent Children	$ ____________________
Social Security Disability	$ ____________________
Other _________________	$ ____________________

☞ Section G—Request for Assistance with Crime Scene Clean Up

☞ Check here if this section does not apply to this Victim/Applicant at this time.

NOTE: Only survivors/dependents of homicide victims may apply for assistance with crime scene clean up. Receipts or supporting documentation must be attached to this application.

"Crime scene clean up" means to remove, or attempt to remove, from the crime scene blood, dirt, stains, or other debris caused by the crime or the processing of the crime scene. Reasonable expenses include, but are not limited to, cleaning supplies, equipment rental, labor, and hazardous waste removal. The location of a crime scene may include a structure or automobile; however, a distinction exists between cleaning and property replacement. Property replacement is prohibited.

Are you seeking reimbursement for expenses incurred during crime scene clean up? ______ Yes ______ No

Was an agency hired to perform the crime scene clean up? ______ Yes ______ No

Do you have receipts or other documentation verifying expenses incurred during crime scene clean up? ______ Yes ______ No

☞ Section H—Miscellaneous Expenses

There may be other expenses eligible for reimbursement from the Arkansas Crime Victims Reparations Board. You may wish to speak with a representative of the Board to determine whether your unique expense is eligible for reimbursement. Other expenses that may be eligible for reimbursement include, but are not limited to:

? Purchase and installation of locks and windows following a sexual assault or act of domestic abuse occurring within the victim's primary residence.

? Travel and lodging resulting from a criminal justice proceeding related to the victimization.

? The application for guardianship of minors following the death of a victim.

ALL APPLICANTS MUST SIGN

(Read Before Signing)

CERTIFICATION OF APPLICATION: I hereby certify, subject to the penalty of fine and imprisonment, that the information contained in this application is true and correct to the best of my knowledge. I understand that if I knowingly file a false claim or provide false information or fail to provide material facts or circumstances necessary to substantiate the claim, I may not at a later date file a correct claim.

NOTE: A.C.A. §16-90-704 and ACVRB Rule No. 16 provide that filing a false claim for reparations shall constitute a Class D felony.

REPAYMENT OF CRIME VICTIM'S COMPENSATION AWARD: You must repay the Crime Victims Reparations Board if you receive payments from the offender (restitution or civil action), insurance, or any other government or private agency as reimbursement for this injury or death after receipt of payment from the Reparations Board.

SUBROGATION AGREEMENT: I hereby agree to notify the Arkansas Crime Victims Reparations Board in the event that additional benefits become available to me in payment of the same expenses for which I receive reimbursement from the Crime Victims Reparations Board. I further agree to retain, as trustee for the Crime Victims Reparations Board, so much of the recovered funds as necessary to reimburse the Reparations Board to the extent of the compensation awarded to me.

X ____ ____________________________

Signature of Applicant/Claimant Date

Relationship to victim if applicant/claimant is other than victim ____

AUTHORIZATION TO RELEASE INFORMATION

(All applicants must sign this release)

I hereby authorize any physician, hospital, medical facility, mental health professional, insurance company, employer, Social Security office, or any other person or firm, agency or organization to furnish confidential information from my records to the Arkansas Crime Victims Reparations Board.

I further authorize the release of all medical and mental health records, including diagnostic records, case notes and toxicology reports that are related to the victimization.

I understand that the purpose of this information is to determine eligibility of crime victim compensation benefits. Only information relevant to this purpose shall be released.

A photocopy or exact reproduction of this signed release shall have the same force and effect as this original.

My signature authorizes release of all such information as specified above.

X ____ ______________________________

Signature of Victim (parent/guardian if victim is minor) Date

Relationship to victim if claimant is other than victim ____